VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 13, 2015

Ms. Holly Baker, Administrator
Manes House
127 Union Street
Bennington, VT 05201

Dear Ms. Baker:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 13, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0193	A. BUILDING: _____ B. WING _____	C 07/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANES HOUSE	127 UNION STREET BENNINGTON, VT 05201

AUG 10 2015

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R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 7/13/15. The following regulatory deficiencies were identified:	R100		
R114 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.a Involuntary Discharge or Transfer of Residents (2) In the case of an involuntary discharge or transfer, the manager shall: i. Notify the resident, and if known, a family member and/or legal representative of the resident, of the discharge or transfer and the specific reasons for the move in writing and in a language and manner the resident understands at least 72 hours before a transfer within the home and thirty (30) days before discharge from the home. If the resident does not have a family member or legal representative and requests assistance, the notice shall be sent to the Long Term Care Ombudsman, Vermont Protection and Advocacy or Vermont Senior Citizens Law Project. ii. Use the form prescribed by the licensing agency for giving written notice of discharge or transfer and include a statement in large print that the resident has the right to appeal the home's decision to transfer or discharge with the appropriate information regarding how to do so. iii. Include a statement in the written notice that the resident may remain in the room or home	R114		

Juanita Mann RN 8-6-15

Deborah Kearns, LPN 8-6-15

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R114	Continued From page 1 during the appeal. iv. Place a copy of the notice in the resident's clinical record. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to provide family members written notice of discharge, 30 days before the discharge from the home for 1 of 2 sampled residents (Resident #1). The findings include the following. Per medical record review, Resident #1 was admitted on 4/8/15. Resident #1 was transferred to the Emergency Room (ER) on 5/23/15 during the evening shift after s/he had become assaultive towards staff by pulling employee's hair, pulling employee's clothing, attempting to bite the employee and scratched the employee's neck breaking the skin. Family was unable to be reached at the time. Licensed Practical Nurse (LPN) was contacted by the staff member and decision was made to send to the ER for evaluation. Medical record does not evidence any communication between the Residential Care Home and/or the ER. There is no evidence in the medical record demonstrating any communication between the hospital staff and/or the RCH ever occurred after transfer. Per interview with the Administrator at 12 noon, confirmation is made that the facility did not provided the resident and/or his/her family with written notification regarding a permanent discharge from the Residential Care Home.	R114	THE MANAGER AS WELL AS THE RN, LPN + ASST. MANAGER HAD BEEN CONSULTED AND THE DECISION JOINTLY MADE TO NOT ACCEPT BACK AS WE FELT SHE WAS A RISK FOR HERSELF, OTHER RESIDENTS AND STAFF. ALTHOUGH CONVERSATIONS DID TAKE PLACE BETWEEN STAFF AND SVMC STAFF OVER THE NEXT COUPLE DAYS, IT WAS NOT DOCUMENTED. POA IS IN THE FUTURE SHOULD SUCH SITUATION OCCUR WE WILL DOCUMENT SUCH CORRESPONDENCE. IT WILL BE OVERVIEWED BY MANAGEMENT AND NURSING. Rec'd 8-12-15 mb/bl	

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R116	Continued From page 2	R116		
R116 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.3 Discharge and Transfer Requirements 5.3.b Emergency Discharge or Transfer of Residents (1) An emergency discharge or transfer may be made with less than thirty (30) days notice under the following circumstances: i. The resident's attending physician documents in the resident's record that the discharge or transfer is an emergency measure necessary for the health and safety of the resident or other residents; or ii. A natural disaster or emergency necessitates the evacuation of residents from the home; or iii. The resident presents an immediate threat to the health or safety of self or others. In that case, the licensee shall request permission from the licensing agency to discharge or transfer the resident immediately. Permission from the licensing agency is not necessary when the immediate threat requires intervention of the police, mental health crisis personnel, or emergency medical services personnel who render the professional judgement that discharge or transfer must occur immediately. In such cases, the licensing agency shall be notified on the next business day; or iv. When ordered or permitted by a court. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to notify the licensing agency of an emergency discharge immediately	R116	We feel we meet the requirement to a emergency transfer and discharge as transfer was made via rescue squad emt's. A police investigator was also called on as referenced in case # 15BN02994 by officer Hanson. On May 1/15 the family was made aware of the possibility of needing to make alternative arrangements due to escalated needs and behaviors. A copy of notation is enclosed. Due to risk of self others and staff we could no longer meet her needs. It had a negative effect on herself as well as the entire house hold. In the future should such a situation occur we will attempt to provide written correspondence to family. As well as guardian and mail within the required time frame. This will be overviewed by management and nursing. Poc entered 8-12-15 mb sl	

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R116	Continued From page 3 or DN the next business day, fDr 1 of 2 sampled residents (Resident #1). The findings include the following. Per medical record review, Resident #1 was admitted on 4/8/15. Resident #1 was transferred to the Emergency Room (ER) on 5/23/15 during the evening shift after s/he had become assaultive towards staff was pulling employee's hair, pulling employee's clothing, attempting to bite the employee and scratched the employee's neck breaking the skin. Family was unable to be reached. The employee contacted the Licensed Practical Nurse (LPN) and decision was made to send to the ER for evaluation. Medical record does not evidence any communication between the Residential Care Home and/or the ER. There is no evidence in the medical record demonstrating any communication with the hospital staff after transfer. Per interview with the Administrator at 12 noon, confirmation is made that the Licensing Agency was never notified of the emergency discharge or the decision to not accept the resident back to the home. Adischarge of this nature would be considered an "emergency discharge" when the home made the decision not to accept the resident back to their home after sending to the ER.	R116		
R136 SS=B	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental	R136		

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R136	Continued From page 4 condition. This REQUIREMENT is not met as evidenced by: Based on medical record review and confirmed by staff interview, the facility failed to reassess 2 of 2 applicable residents after a significant change in Resident #1 and #2's physical and/or mental condition. The findings include the following: 1. Per medical record review, progress notes identify that Resident #2 was returned to the Residential Care Home (RCH) on 5/21/15 after a 45 day Medical Leave of Absence (MLOA). The resident developed a fractured hip after a fall in the RCH. The hip was surgically repaired and a short stay rehab admission to a skilled nursing facility was necessary to enable Resident #2 to return to the RCH. Per review of the medical record, the last resident assessment was completed on 7/24/14. Confirmation was made by the Registered Nurse at 1:30 PM that the resident has not had a reassessment after the 45 day leave and change in status nor has the resident been reassessed since 3/11/14 by the RN to ensure safety with self-administration of injectable insulin. The insulin dosage has changed since the Resident #2's hospitalization. 2. Per medical record review at 12 noon, Resident #1 was admitted on 4/8/15 with diagnosis to include Cerebral Vascular Accident (CVA) with hemiparesis, Chronic Expressive Aphasia, Hypertension, Depression with Suicidal Ideation and Dysarthria.	R136	① WE RECOGNIZE OUR ERROR IN NOT HAVING COMPLETED A NEW ASSESSMENT AND ONLY MADE UPDATED NOTES IN THE old ASSESSMENT. A new ASSESSMENT HAS BEEN COMPLETED ON 7-28-15 ENCLOSED IS THE SIGNED LAST PAGE OF THE ASSESSMENT. IN THE FUTURE WE WILL BE SURE TO COMPLETE A NEW ASSESSMENT UPON ANY REASONS. THIS OVERSEEN BY MANAGEMENT AND NURSING. ② IN THE FUTURE WE WILL BE SURE TO REDO ANY ASSESSMENTS WHERE THERE ARE SUBSTANTIATED CHANGES IN CONDITIONS. THIS WILL BE OVERSEEN BY MANAGEMENT AND NURSING. ③ ALSO A REASSESSMENT FOR THIS RESIDENT WAS DONE ON 7-24-15 FOR THE ABILITY TO SELF ADM. INSULIN THIS HAD NOT BEEN EFFECTED BY HER INJURY AS SHE RETURNED FROM REHAB FUNCTIONING @ BASELINE EXCEPT WALKER. only IN HALLWAYS. ON 5-28-15 STEVE RUCKER F.N.P. HAD SIGNED ALL ORDERS OLD/NEW WHICH INCLUDED SELF ADM. of INSULIN. INCLUDED IN AN UPDATED ORDER FOR SUCH ON 7-31-15 THIS WILL BE OVERSEEN IN THE future BY MANAGEMENT AND NURSING. ENCLOSED FIND SUPPORTING DOCUMENTS AND UPDATED COPY OF Appt. INFO SHEET REFLECTING SUCH. Received 8-12-15 MS/LW	

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R136	Continued From page 5 Resident assessment completed by the Registered Nurse (RN) on 4/24/15. Nursing progress notes identify medication adjustments related to behaviors on three (3) different occasions, multiple episodes of agitation, assaultive/aggressive behavior and the need for the administration of as needed (PRN) medication for anxiety. Documentation also identifies that Resident #2, on numerous occasions was drinking excessive amounts of fluids, would request multiple desserts and would vomit after excessive intake. Per interview with the RN at 12 noon, confirmation is made that a significant change in condition assessment was never completed for Resident #1 despite the multiple changes in the residents physical and mental status.	R136		
R145 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on medical record and confirmed by staff interview, the facility failed to develop and update a written plan of care for 2 of 2 sampled residents. (Resident #1 and Resident #2.) The findings include the following:	R145		

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R145	Continued From page 6 1. Per medical record review, Resident #2 returned to the Residential Care Home (RCH) on 5/21/15 after a 45 day Medical Leave of Absence (MLOA). The resident developed a fractured hip after a fall in the RCH. The hip was surgically repaired and a short stay rehab admission to a skilled nursing facility occurred, to assist Resident #2 on returning to the RCH. Per review of the medical record, the Resident Care Plan dated 4/16/15 identifies Fractured right hip and 5/21/15 identifies return to the RCH. The plan of care does not describe the services necessary to maintain Resident #2's independence and well-being. Confirmation was made by the Registered Nurse at 1:30 PM that the resident care plan does not address current needs for pain management, physical therapy and self administration of subcutaneous insulin administration. 2. Per medical record review, Resident #1 was admitted on 4/8/15. Resident care plan dated 4/23/15 and signed by the Registered Nurse (RN) identifies special instructions to the staff as follows: Can be demanding, need to be consistent but firm with responds to persistent demands. Nursing progress notes identify medication adjustments related to behaviors on three (3) different occasions, multiple episodes of agitation, assaultive/aggressive behavior and the need for the administration of as needed (PRN) medication for anxiety. Documentation also identifies that Resident #2, on numerous occasions was drinking excessive amounts of fluids, would request multiple desserts and would vomit after excessive intake.	R145	(1) NOTES HAD BEEN MADE ON THE OLD CARE PLAN. A NEW CARE PLAN WAS BEEN DEVELOPED FROM THE NEW ASSESSMENT DATED 7-28-15. PLEASE SEE ENCLOSED COPIES. IN THE FUTURE NEW CARE PLANS WILL BE DEVELOPED AS ABOVE AND OVERVIEWED BY MANAGEMENT AND NURSING (2) SEE NEXT PAGE per email 8-12-15 MS/BRL	

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R145	Continued From page 7 Per interview with the RN at 12 noon, confirmation is made that the Care Plan has not been updated after any of the medication adjustments nor has the team developed any new non pharmacological interventions to assist the resident to deal with the anxiety and responses to staff direction.	R145	(2) IN THE FUTURE THE CARE PLANS WILL BE REVISED FROM THE SUSTANTIATED FINDINGS AND OBSERVERED BY MANAGEMENT AND NURSING TO REFLECT NEW INTERVENTIONS, CHANGE IN NEEDS IN PSYCHO/SOCIAL ISSUES AND NON NEW INTERVENTIONS THAT WILL ASST. STAFF AS WELL AS MEET THE RESIDENTS NEEDS. POC count 8-12-15 MB KM	